Bulletin Number 98-003 October 14, 1998

PAYMENT OF CLAIMS AND PAYMENT FOR SERVICES OF MEDICAL PROVIDERS

The Department of Business and Industry, Division of Insurance (Division) has received an increased number of complaints from consumers and medical providers regarding the late payments by insurers and health maintenance organizations (HMOs). Delayed claims payments to insureds violate the Unfair Trade Practices Act (NRS 686A) and the regulations adopted pursuant to it. Payments to medical providers who hold valid assignments of an insured person's financial benefit are governed by the same sections of the insurance code. Payments to providers under service contracts with HMOs or insurers using Preferred Provider Organizations (PPOs) will be governed by those provider contracts and the Division's authority under NRS 680A.200(2)(a), NRS 695C.070 and NRS 695C.080.

It is the position of the Division that insurers must make the required payments under either contract within 30 days of the acceptance for the claim under the insurance policy or the request for payment under the provider service contract. If additional information is required to determine the validity of the claim or request for payment, the request must be made within 20 days of receiving the claim or request for payment. In the absence of a written contractual provision that states a different rate of interest, NRS 99.040 requires that interest must be paid to the payee for late payments in addition to the claim amount.

The force of this bulletin applies to the actions of third party administrators. See NAC 683A.100 (definition of "insurer").

An insurer or HMO may "pend" a claim or a request for payment if legitimate additional information is needed as long as the insurer gives the payee a specific reason(s) for the required information. Payments owed but unpaid in full or in part to any payee for the reasons listed below are violations of one of the aforementioned laws. The following reasons are illegal evasions of the requirement for timely payment:

1. The pending of a claim or a request for payment without a reason or with the use of non-specific terms such as "pended";
2. The holding of claims or requests for payment for such a time that they become "stale" and require resubmission;
3. The partial settlement of a fully payable claim or request in one payment cycle with the balance paid at a future date; and
4. The requirement for information that has been shown to have been previously furnished.

Any variations of these practices or other practices that result in the same delaying tactics are also violations.

The business of managed care organizations, as defined by chapter 695G of the NRS, requires executed provider contracts between insurers, or their representatives and medical providers. The provisions of those contracts may not violate the insurance laws.

The Division reminds managed care organizations that NRS 695G.250 prohibits retaliation against medical providers for reporting violations of the law.
The commissioner of insurance will aggressively pursue violations as they concern any payee. Violators will be subject to disciplinary action, including fines or the suspension or revocation of a certificate of authority, pursuant to NRS 680A.200, NRS 683A.450, NRS 686A.183, NRS 695C.330, or NRS 695C.350, as those statutes may apply to the particular licensee.

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Commissioner of Insurance